Pregnancy Questionnaire

NAME: ___________________________________________ DATE OF BIRTH: ______________________

Although we may already have some of the information that we are asking for in this form, the initiation of prenatal care is an important time to thoroughly review your medical history and current health.

Is there a phone number(s) where we can leave confidential messages, such as test results/special instructions, for today’s visit as well as for the future? If yes:

Phone Number: __________(home) ______________(mobile) ____________________(work)

Name of Baby’s Father: __________ Father’s Phone Number: __________(home) __________(mobile) __________(work)

OBSTETRIC HISTORY:

# Pregnancies: ___  # Deliveries: ___  # Abortions: ___  # Miscarriages: ___  # Ectopic Pregnancies: ___

First day of most recent period: (LMP) _______  Are your periods regular? □ Yes □ No

Positive hcg/pregnancy test? □ Yes □ No  Did you have fertility treatment with this pregnancy? □ Yes □ No

If you took fertility medications, which one(s) did you take? _______________________________

Pregnancies: (outcome is vaginal delivery, cesarian, miscarriage, abortion or ectopic)

<table>
<thead>
<tr>
<th>Date</th>
<th>Outcome</th>
<th>Gestation at time of delivery</th>
<th>Living</th>
<th>Hours in Labor</th>
<th>Weight of Baby</th>
<th>Sex</th>
<th>Name of Baby</th>
<th>Comments</th>
<th>Hospital</th>
<th>M.D.</th>
<th>Anesthesia</th>
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Age at onset of menses: ______________  Cycle: ______ days (start to start) Usual duration: ___________ days

Flow: □ Light □ Medium □ Heavy  Pain or cramps? □ Yes □ No

PAST OR CURRENT MEDICAL PROBLEMS:

<table>
<thead>
<tr>
<th>Please check one</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>diabetes</td>
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<td>high blood pressure</td>
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<td>heart disease</td>
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<td>varicose veins, blood clots in veins</td>
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<tr>
<td>anemia, blood disorder</td>
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<td>neurological problem, seizures</td>
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<td>migraines</td>
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<td>allergies, hay fever, chronic sinusitis</td>
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<td>autoimmune disease</td>
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<td>hepatitis, liver disease</td>
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<td>thyroid disorder</td>
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<td>kidney or bladder disease</td>
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<td>lung problem, asthma, tuberculosis</td>
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<td>breast problems</td>
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</table>
Other Medical Problems: ____________________________________________________________
Details of positive responses: ______________________________________________________

SURGERIES AND APPROXIMATE DATES (month/year):
1. __________________________________________  3. _______________________________________
2. __________________________________________  4. _______________________________________

IMMEDIATE FAMILY MEMBERS WHO HAVE:
Diabetes______________________  Colon cancer______________________
High blood pressure____________  Prostate cancer____________________
Heart attack/stroke______________  Thyroid cancer____________________
High cholesterol________________  Alcoholism_______________________
Breast/ovarian cancer____________  Depression/suicide_______________
Dementia/Alzheimer’s___________  Other___________________________

SOCIAL HISTORY:
Have you ever smoked?  □ Yes  □ No  □ Current smoker  □ Quit (month/year): ____________________________
If yes, how many packs per day?  □ <1  □ 1  □ 2  □ >3  For how many years? ____________________________
Do you drink alcohol?  □ Yes  □ No  If yes, how many drinks per week?  □ <1  □ 1-4  □ 5-10  □ >20
Have you ever used recreational drugs?  □ Yes  □ No  If yes, what drug(s) ________________________________
Method of birth control prior to pregnancy: ______________________________________________________
Who lives at home with you? ________________________________________________________________
Do you own cats?  □ Yes  □ No
If you have a partner, has he or she ever hit you, kicked you or threatened to harm you?  □ Yes  □ No
What is your occupation? _________________________________________________________________
Are you exposed to any occupational chemicals?  □ Yes  □ No  If yes, which chemical(s) ________________
Marital status:  □ Single  □ Partnered/Married  □ Divorced  □ Widowed  □ Other
If you have a domestic partner/spouse, what is his or her name? ____________________________________
Highest level of education:  □ Elementary  □ Junior High  □ High School  □ College  □ Graduate School

HEALTH CARE MAINTENANCE TESTS
Last Pap smear (month/year): ____________________________  □ Normal  □ Abnormal

MEDICATION ALLERGIES/REACTION
_______________________________________________________________
____________________________________________________________________________

MEDICATIONS: (prescription medications, birth control, aspirin, vitamins/herbals, supplements) Everything since your last period
Medication                  Dose (mg.)           Times per day
1. __________________________________________  3. _______________________________________
2. __________________________________________  4. _______________________________________

**Is there anything confidential you would like to discuss in private with your provider?  □ Yes  □ No
Please answer all questions:

Will you be 35 years old or older when the baby is due? .................................................. Yes  No  Don’t Know

Have you, the baby’s father or anyone in either family ever had any one of the following disorders:

A. Thalasemia ........................................................................................................................................
B. Neural Tube Defect, Spina Bifida (Open Spine), Anencephaly ..............................................
C. Congenital Heart Defect ............................................................................................................
D. Down Syndrome ........................................................................................................................
E. Tay-Sachs ......................................................................................................................................
F. Canavan Disease ........................................................................................................................
G. Sickle Cell Disease or Trait .........................................................................................................
H. Hemophilia or Blood Disorder ...................................................................................................
I. Muscular Dystrophy ...................................................................................................................
J. Cystic Fibrosis ............................................................................................................................
K. Huntington’s Chorea ...................................................................................................................
L. Mental Retardation ......................................................................................................................
M. Any other Genetic or Chromosomal Disorder ........................................................................

Do you, the baby’s father or a close family member of either of you have a birth defect or a chromosomal abnormality not listed above?  ☐ Yes  ☐ No  ☐ Don’t Know

Have you or the baby’s father had a stillborn baby or three or more first trimester miscarriages?  ☐ Yes  ☐ No  ☐ Don’t Know

If you answered yes to any of the above questions, please indicate the condition and the relationship of the affected person to you or the baby’s father: ________________________________________________________________

INFECTION SCREENING:

Do you live with someone with TB or have you been exposed to TB? ........................................
Do you or your partner have genital herpes? ........................................................................
Have you had a rash or viral illness since your last period? ....................................................
Have you had Gonorrhea, Chlamydia, HPV or Syphilis? ............................................................
Have you had the chicken pox or varicella vaccine? .................................................................

Signature__________________________________________ Date____________